ALL APPROVED NURSE AIDE I FACULTY MUST MEET THE FOLLOWING CRITERIA

Please use the information below to evaluate potential faculty. Use the Faculty Approval Request Form to include information that demonstrates these requirements.

DO NOT RETURN THIS PAGE WITH THE APPROVAL FORM.

PROGRAM COORDINATOR (Nurse Aide Training, Refresher or Transition Course)

YES	NO	REQUIREMENTS					
		1. The applicant is a registered nurse with an unencumbered license.					
		2. The applicant is licensed to practice in North Carolina.					
		3. The applicant has at least two (2) years of experience as a registered nurse.					
		4. The applicant has at least one (1) year (2000 hours) of RN experience in the provision of long term care facility services demonstrated by:					
		a. working in a long term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital, <u>or</u>					
		b. supervising or teaching students in a long term care facility licensed as a skilled nursing facility or a skilled nursing facility which is a distinct part of a hospital.					

PRIMARY OR ADDITIONAL INSTRUCTOR (Nurse Aide Training Course)

YES	NO	REQUIREMENTS				
		1. The applicant is a registered nurse with an unencumbered license.				
		2. The applicant is licensed to practice in North Carolina.				
		3. The applicant has at least 2 years of experience as a registered nurse.				
		4. The applicant meets at least one of the following:				
		a. completion of a course in teaching adults,				
		b. experience in teaching adults, or				
		c. experience in supervising nurse aides.				

Division of Health Service Regulation Health Care Personnel Registry Section Center for Aide Regulation and Education 2709 Mail Service Center Raleigh, NC 27699-2709 Telephone: 919-855-3970 or 919-855-3969

Fax: 919-733-9764

FACULTY APPROVAL REQUEST FORM

Nurse Aide I Program

North Carolina Division of Health Service Regulation

Please use this form as a template to make additional copies. Any time you add faculty, a new form must be completed and submitted to our office for approval. To remove faculty, please use the Faculty Removal Form.

Sch	ool/Facility	
Str	eet	
City	y Cour	nty Zip Code
Are	ea Code, Telephone Number & Direct Extension	
Fax	z Line E-Mail A	Address
NI	IRSE AIDE I TRAINING PROGRAM NUMBER(S) (NAT ONL	Y)
11	RANSITION COURSE PROGRAM NUMBER(S)	
	POSITION(S) REQUESTED:	APPLICANT'S NAME AS IT APPEARS ON RN LICENSE
ı	Please check (✓) below	(PLEASE PRINT)
	PROGRAM COORDINATOR FOR NAT	(
г	PROGRAM COORDINATOR FOR REFRESHER	
	PROGRAM COORDINATOR FOR TRANSITION	
	PRIMARY INSTRUCTOR (NAT ONLY)	
	ADDITIONAL INSTRUCTOR (NAT ONLY)	
□ I (*No be n Dat I ce requ Sign	ote: If temporary NC RN number is assigned, DFS must notified when permanent NC RN license number is issued) Re of Original RN Licensure Month/Year retify that the information in this application is correct and a uirements for the position(s) requested have been met. nature Applicant nature Nurse Aide I Program Coordinator/Administrator/Direction Nurse A	N License in Good Standing
	COMPLETE SECTIONS 1 - VI ONLI IF REQUESTI	TO MIT TROUBLE CONDITION ON FACULT
I.	NURSING EDUCATION	INDICATE HIGHEST EDUCATION
		LEVEL:
	College/University/School of Nursing Name	□ ADN
	Coneger conversity/ischool of realising realise	□DIPLOMA
	Street Address	□BS
	Street Address	□ MSN
	City Ctata 72 Cal	□Other:
	City State Zip Code	
II.	OTHER EDUCATION: College/University	
	Discipline	Degree

Name of Applicant:	

PLEASE INCLUDE RN EXPERIENCE THAT DEMONSTRATES CRITERIA ONLY

III. REGISTERED NURSING EMPLOYMENT HISTORY:

DATES From:	Month Day Year To: Month Day Year
NURSING FACILITY 1	<u>EMPLOYER</u>
Facility	Position
	□ Full time
City/State/Zip	Part time:
Phone/Area Code	average number of hours worked per week
☐ Nursing Home	☐ ICF/MR ☐ Med/Surg ☐ Hospital SNF ☐ Home Health/Hospice
☐ Swing Bed Unit	☐ Supervised nurse aides as part of job ☐ Cared for chronically ill or elderly
☐ Other (Specify)	
DATES From:	To:
	Month Day Year Month Day Year
NURSING FACILITY	<u>EMPLOYER</u>
Facility	Position_
Type of Facility	
Address	□ Full time
City/State/Zip	Part time:
Phone/Area Code	average number of hours worked per week
☐ Nursing Home	☐ ICF/MR ☐ Med/Surg ☐ Hospital SNF ☐ Home Health/Hospice
☐ Swing Bed Unit	☐ Supervised nurse aides as part of job ☐ Cared for chronically ill or elderly
☐ Other (Specify)	
DATES From:	То:
DATES FIOR.	Month Day Year Month Day Year
NURSING FACILITY I	EMPLOYER
Facility	Position
Type of Facility	
Address	
	□ Part time:
Phone/Area Code	average number of hours worked per week
☐ Nursing Home	☐ ICF/MR ☐ Med/Surg ☐ Hospital SNF ☐ Home Health/Hospice
☐ Swing Bed Unit	☐ Supervised nurse aides as part of job ☐ Cared for chronically ill or elderly
☐ Other (Specify)	-

DATES	From:	Month	Day	Year		To:	
EMPLOYER		11201111	Duy	1001		Month Buy Tour	
Facility						Describe teaching experience	
City/State/Zip_ Phone/Area Co							
DATES	From:					To:	
		Month	Day	Year		Month Day Year	
EMPLOYER							
Facility						Describe teaching experience	
Address City/State/Zip_							
Phone/Area Co							
DATES	From:					To:	
		Month	Day	Year		Month Day Year	
EMPLOYER							
Facility Address						Describe teaching experience	
City/State/Zip_							
Phone/Area Co							
V. <u>TEACHIN</u>	IG MET	HODOL	OGY CO	URSE			
Sponsored	Ву						
Address							
ridar css		Street			City	State	Zip Code
Course con	tent:					Date Con	npleted
7T A 1 1040	inform.	ation role	ted to the	o mognin	omonts	you may want considered:	

Complete and return to: Division of Health Service Regulation

Health Care Personnel Registry Section Center for Aide Regulation and Education

2709 Mail Service Center

Raleigh, North Carolina 27699-2709

Training Program line: (919) 855-3970 Fax: (919) 733-9764